STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004686	A. BUILDING: _____ B. WING _____	C 08/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON PLACE	2116 BUTLER RD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00154719. Complaint IN00154719 - Unsubstantiated due to lack of evidence. Survey date: August 26, 2014 Facility number: 004686 Provider number: N/A AIM number: N/A Survey team: Rick Blain, RN - TC Carol Miller, RN Census bed type: Residential: 11 Total: 11 Census payor type: Other: 11 Total: 11 Sample: 3 Hamilton Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00154719.	R 000		